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Medicare Has Improved



Catastrophic Protection
and
Other New Benefits

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An Official Notice To Medicare Beneficiaries
Explaining Benefits Under The Medicare
Catastrophic Coverage Act of 1988
(Public Law 100-360)

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MEDICARE EXPANDED TO INCLUDE CATASTROPHIC HEALTH INSURANCE

Medicare has been changed to better protect its 32 million elderly and disabled beneficiaries from "catastrophic" hospital, doctor and prescription drug bills. The first of the changes, mandated by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), were introduced January 1, 1989. Other changes will become effective over the next few years.

The new law limits the amount you as a Medicare beneficiary must pay for hospital care, physician services, medical supplies, and outpatient prescription drugs covered by Medicare. It increases home health, skilled nursing facility, and hospice coverage, and adds breast cancer screening and respite care benefits.

These new and improved benefits will be made available to you automatically if you are a Medicare beneficiary or when you become eligible for the program. You are not required to do anything to receive this coverage. If you are enrolled in Part A only and want to enroll in Part B to take advantage of all of the benefits, you will be given a chance to do so during the general enrollment period from January 1 through March 31 each year.

NEW HOSPITAL INSURANCE (PART A) BENEFITS

Medicare Hospital Insurance (Part A) helps pay for medically necessary care in a Medicare-approved hospital, skilled nursing facility and hospice. It also pays for certain home health care. Most of the new Part A benefits became effective January 1, 1989.

NEW HOSPITAL BENEFITS

Under the new law you are entitled to unlimited hospitalization and approved care after you pay a single annual deductible (\$560 for 1989). A deductible is an amount you must spend before Medicare begins paying for services and supplies covered by the program. Medicare will pay for your hospital care only if you meet the following four conditions: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

Once you meet these conditions and pay the single annual deductible, Medicare pays 100 percent of the approved charges for your care. This is regardless of the costs, length of stay or number of times you are admitted to the hospital in any one year. And if you pay the deductible during December, you do not have to pay it again if you are still a patient in or are readmitted to the hospital in January of the following year.

While most hospital-related costs are covered by Medicare, you must pay for certain services and conveniences, such as a private room (unless it is a medical necessity), private duty nurses, a television, radio, or telephone in the room.

NOTE: The 190-day lifetime limit on inpatient psychiatric hospital services remains unchanged.

SKILLED NURSING FACILITY CARE

The new law provides for 150 days of care per calendar year in a Medicare-certified skilled nursing facility. If you are admitted to a skilled nursing facility, you will be responsible for copayments (a share of the costs) for the first eight days of care each year. The copayment is \$25.50 per day in 1989. Medicare pays all other allowable charges for up to 150 days of covered care even if you are discharged and readmitted to a skilled nursing facility more than once during a calendar year. The requirement that you be hospitalized at least three days immediately before entering a skilled nursing facility to qualify for Medicare coverage was eliminated for stays starting on or after January 1, 1989.

Skilled nursing facility care is not the same as custodial nursing home care. Skilled nursing facility care is acute care while custodial nursing home care is often long-term care. A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation and other related health services. Most nursing homes in the United States are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare. While Medicare does not cover custodial care in a nursing home, some insurance companies offer policies that do.

HOSPICE CARE

Unlimited hospice care is now available to beneficiaries who are recertified as terminally ill after 210 days of care in a Medicare-certified hospice program.

HOME HEALTH CARE

To qualify for Medicare coverage of home health services, you must be confined to your home; you must be under a physician's care and under a plan of care established and approved by a physician; you must need skilled nursing care on an intermittent basis, or physical therapy or speech therapy or continued occupational therapy. If you meet these conditions, Medicare will cover services provided by a Medicare participating home health agency.

The Medicare home health care benefit covers reasonable and necessary skilled nursing care and/or home health aide care for up to 28 hours a week on an intermittent basis (not daily) or on a part time basis (less than eight hours a day; can be daily). The 28 hour limit may be extended in special cases.

If you require skilled nursing care and home health aide services full time (eight hours a day) they may be covered for up to 21 consecutive days. The 21 day period can be extended in special cases. Beginning January 1, 1990, these services may be covered for up to 38 consecutive days. The 38 day period can be extended in special cases.

The Medicare home health care benefit also covers speech, physical and occupational therapy, medical social services, medical supplies, and a portion of the cost of durable medical equipment.

DOCTOR AND OTHER OUTPATIENT SERVICES (Part B)

Medicare Part B helps pay for medically necessary doctor services, outpatient hospital services, home health care, and various

medical services and supplies not covered by the hospital insurance part of Medicare. It is voluntary, and enrollees pay a monthly premium.

Effective January 1, 1990, your share of approved charges for services and supplies covered by Part B will be limited to \$1,370 a year. You will be required to pay the first \$75 (deductible) of charges approved by Medicare and 20 percent of all approved charges after that until these out-of-pocket expenses total \$1,370. It does not matter whether these expenses are paid directly by you or by your private insurance company. Once the \$1,370 amount is reached, Medicare will pay 100 percent of all other approved charges under Part B for the remainder of the calendar year. (An approved charge is an amount Medicare has determined to be a reasonable price for physicians and other covered medical services.)

If a doctor or medical supplier charges more than Medicare's approved charge, you must pay the difference and it will not count toward the \$1,370 limit. You will continue to be responsible for any charges over what Medicare allows even after you reach the \$1,370 out-of-pocket limit.

Some doctors and suppliers agree to charge no more than the Medicare-approved amount for services and supplies. They are called participating physicians and suppliers and you can get their names and addresses from the Medicare carrier for your area.

RESPITE CARE BENEFIT

This new benefit, *effective January 1, 1990*, provides temporary relief for a person who lives with and normally helps a Medicare

beneficiary who requires assistance with essential daily personal care. Medicare will pay for up to 80 hours per year of home health aide care, nursing care provided by a licensed professional nurse, and personal care services. You can use this benefit only if you are chronically dependent and have met either the annual deductible for outpatient prescription drugs or the \$1,370 Part B catastrophic limit for the year.

MAMMOGRAPHY

This new benefit, *which goes into effect January 1, 1990*, will pay up to \$50 for an X-ray screening for the detection of breast cancer. Women 65 or older can use the benefit for a mammogram every other year, while certain younger disabled women covered by Medicare can use it for more frequent examinations.

NEW PRESCRIPTION DRUG BENEFIT

Medicare already pays for prescription drugs when you are in the hospital. *Beginning January 1, 1990*, the benefit will be expanded to cover a few outpatient prescription drugs in certain circumstances, *and in 1991 it will cover most prescription drugs as well as insulin.*

In 1990, Medicare will help pay for certain drugs that are injected into the veins (intravenous) and can be safely used at home. In 1990, you will have to pay the \$550 drug deductible (unless your drug treatment was begun in the hospital) for covered home intravenous drugs. Medicare will then pay 80 percent of the Medicare approved charges for intravenous drugs provided at home. In years after 1990, the deductible will be the same as that applying to all other prescription drugs.

Medicare already pays 80 percent of the approved charges for prescription drugs used in immunosuppressive therapy if the drugs are furnished within the first year following a Medicare-covered organ transplant. This first year coverage at 80 percent will continue during 1989 and years following, with no drug deductible. In the case of these drugs, the regular medical insurance \$75 deductible applies only during 1989.

Starting in 1990, Medicare will also cover prescription drugs used in immunosuppressive therapy for other than first-year post-transplant use. During 1990, Medicare will pay 50 percent of the approved charges after you have paid the \$550 deductible. In years after 1990, the drug deductible will be the same as that applying to all other prescription drugs; and the amount Medicare will pay will increase from 50 percent to the percentage applying to all other prescription drugs. (See explanation of coverage of all prescription drugs below.)

Effective January 1, 1991, Medicare will cover most other prescription drugs as well as insulin. You will be responsible for an annual deductible and coinsurance payments. In 1991, the deductible will be \$600 and the coinsurance 50 percent. This means that after you pay the first \$600 for covered outpatient prescription drugs, Medicare will pay half of all other allowed drug charges for the remainder of the calendar year. In 1992 the deductible will be \$652 and the coinsurance payment 40 percent of allowed charges. In 1993 and thereafter, if the new catastrophic coverage premiums have been sufficient to cover costs, Medicare will pay 80 percent of all the allowable charges in excess of the deductible. The deductible for 1993 is yet to be set.

PAYING FOR CATASTROPHIC HEALTH INSURANCE

Two new premiums have been added to pay for the catastrophic coverage. One is an addition to the basic monthly Part B premium and the other is a new annual income-tax-related premium. The extra charge (or surcharge) added to the basic Part B premium is \$4 per month in 1989 and will gradually increase to \$10.20 per month in 1993. This surcharge is in addition to any increases in the monthly basic Part B premium (\$27.90 in 1989).

If you are a Social Security or Railroad Retirement beneficiary, any increase to you in the Part B premium cannot be greater than the cost-of-living adjustment in your monthly benefit for the year. In other words, if at some time in the future the Part B premium were increased \$6 per month and your cost-of-living adjustment for the year amounted to \$5 a month, the increase in your monthly premium would be limited to \$5.

While enrollment in Part B is still optional, you cannot buy Part B without also buying the new catastrophic benefits it provides. Everyone* enrolled in Part B will be required to pay the catastrophic benefits surcharge added to the basic Part B premium. Part B premium payments will not count toward the \$1,370 out-of-pocket expense limit.

*If you do not have an earned entitlement to Medicare, and you purchase Part B, you do not have to pay the \$4 monthly surcharge for 1989. You will, however, be assessed a Part B surcharge beginning January 1, 1990.

SUPPLEMENTAL PREMIUM

Besides the change in the Part B premium, a supplemental premium based on your income tax liability is to be paid on Federal tax returns for 1989.

You must pay the supplemental premium if you are entitled to or eligible for Medicare Part A for at least six full months in the taxable year and your Federal income tax liability for the year is \$150 or more. The only exceptions are for certain Medicare-eligible individuals living in a foreign country and those who pay a monthly premium for Part A coverage. You do not have to pay the supplemental premium if your tax liability for the taxable year is less than \$150.

The supplemental premium rate is \$22.50 for each \$150 of Federal income tax liability for the 1989 tax year. This means that if you pay \$150 in Federal income taxes for 1989, your supplemental premium will be \$22.50. If your tax is \$300, the premium will be \$45. The premium rate for each \$150 of tax liability will rise to \$37.50 in 1990, \$39 in 1991, \$40.50 in 1992, and \$42 in 1993. There is, however, a limit on the amount you must pay each year. For 1989, the maximum supplemental premium is \$800. It will increase to \$850 in 1990, \$900 in 1991, \$950 in 1992, and \$1,050 in 1993.

The maximum is double for a married couple filing a joint return as long as both were eligible for Part A for at least six full months during the taxable year. Thus, a couple will pay a supplemental premium in 1989 at the rate of \$22.50 for each \$150 up to a maximum of \$1,600. In the case of a joint return where only one spouse is eligible for Medicare, only

one half of any tax liability is taken into account, and the \$800 maximum applies. There are also special rules for governmental retirees to adjust for the fact that government annuities are fully taxed while most Social Security pensions are not.

The supplemental premium will be administered by the Internal Revenue Service (IRS), and collected with your income tax payments. You will receive information, including a tax table for computing the premiums, from the IRS in your 1989 tax package.

The supplemental premium does not count toward the \$1,370 out-of-pocket expense limit for Part B benefits.

PREPAYMENT PLANS

If you are enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP), the new catastrophic coverage will be provided by your HMO or CMP. Additional information about this coverage and how it is to be provided by the plans is discussed in the pamphlet "Medicare and Prepayment Plans," which is available from your local Social Security office. If you are a Federal retiree enrolled in the Federal Employees Health Benefits Program, special provisions of the new law may apply to you. All questions about these provisions should be directed to the Office of Personnel Management, P.O. Box 275, Washington, D.C. 20044-0275.

MEDIGAP POLICIES

As the new and improved Medicare benefits are introduced, insurance companies will change their Medicare supplement insurance policies and premiums. You may wish to re-evaluate your insurance needs based on your health status and finances as these changes take effect. Contact your State insurance commissioner or insurance agent for additional information about Medicare supplement, or so-called "Medigap" policies. You may also want to get a copy of the pamphlet "Guide to Health Insurance for People with Medicare," from your local Social Security office.

WHERE CAN I GET MORE INFORMATION?

If you need more information about your benefits under the new law, you may call the Medicare catastrophic coverage hotline at 1-800-888-1998. If you need general information about Medicare or you have a question about a Medicare claim, you should contact the Medicare carrier that processes claims for your area. (The carrier's telephone number is listed in *The Medicare Handbook*. If you do not have a Handbook, you may call the hotline number given above to get the carrier telephone number.)

Questions about the income tax-related supplemental premium should be directed to the Internal Revenue Service.

SUMMARY OF NEW BENEFITS

Hospital Insurance (Part A)

***Hospital Care:**

Beneficiary pays an annual deductible of \$560 in 1989 and Medicare pays the balance regardless of the number of days of hospitalization or the costs.

***Skilled Nursing Facility Care:**

150 days of care per year with copayment of \$25.50 per day for the first 8 days in 1989.

***Hospice Care:**

Unlimited care if recertified as terminally ill after 210 days of care.

***Home Health Care:**

As of January 1, 1990, up to 38 consecutive days of medically necessary full-time skilled nursing care and home health aide services.

Medical Insurance (Part B)

***Medical Benefits:**

Beginning January 1, 1990, beneficiary pays \$75 deductible and 20 percent copayment up to \$1,370. Medicare then pays all other allowable charges for the rest of the year.

***Drug Benefit:**

Certain drugs covered in 1990. Most prescription drugs, insulin covered in 1991 with Medicare paying 50 percent of allowable charges over \$600 deductible. In 1992, Medicare pays 60 percent of allowable charges over \$652 deductible. If finances permit, Medicare pays 80 percent of allowable charges over yet-to-be set deductible in 1993.

